IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
_____ DIVISION

YOLANDA MACKEY
(Enter Above the Name of the Plaintiff in this Action)

vs.

Columbus Center For Human Services
(Enter above the name of the Defendant in this Action)

2:17 CV 846

Judge Graham

MAGISTRATE JUDGE JOLSON

If there are additional Defendants, please list them:

_____

_____

_____

_____

COMPLAINT

I. Parties to the action:

Plaintiff: Place your name and address on the lines below. The address you give must be the address where the court may contact you and mail documents to you. A telephone number is required.

YOLANDA Ameila MAckey
Name - Full Name Please - PRINT

1187 Seymour Ave.
Street Address

Columbus, Ohio 43204
City, State and Zip Code

(614) 591-1106
Telephone Number

If there are additional Plaintiffs in this suit, a separate piece of paper should be attached immediately behind this page with their full names, addresses and telephone numbers. If there are no other Plaintiffs, continue with this form.

Defendant(s):

Place the name and address of each Defendant you listed in the caption on the first page of this Complaint. This form is invalid unless each Defendant appears with full address for proper service.

1. Columbus Center For Human Services
Name - Full Name Please
540 Industrial mile rd. Columbus, Ohio 43228
Address: Street, City, State and Zip Code

2. _____

3. _____

4. _____

5. _____

6. _____

If there are additional Defendants, please list their names and addresses on a separate sheet of paper.

II. Subject Matter Jurisdiction

Check the box or boxes that describes your lawsuit:

☑ Title 28 U.S.C. § 1343(3)
[A civil rights lawsuit alleging that Defendant(s) acting under color of State law, deprived you of a right secured by federal law or the Constitution.]

☐ Title 28 U.S.C. § 1331
[A lawsuit "arising under the Constitution, laws, or treaties of the United States."]

☐ Title 28 U.S.C. § 1332(a)(1)
[A lawsuit between citizens of different states where the matter in controversy exceeds $75,000.]

☐ Title _____ United States Code, Section _____
[Other federal status giving the court subject matter jurisdiction.]

III. Statement of Claim

Please write as briefly as possible the facts of your case. Describe how each Defendant is involved. Include the name of all persons involved, give dates and places.

Number each claim separately. Use as much space as you need. You are not limited to the papers we give you. Attach extra sheets that deal with your statement claim immediately behind this piece of paper.

(1) YOLANDA MACKEY was injured on April 22, 2014 Sprain / Strain Lumbar 847.2 Also Sprain / Strain Shoulder / Upper Arm 840.8 Due to work all by myself on shift Fairly new. The other staff never showed up to train me, on April 22nd until 6-7 hrs later when I Phoned the office about me getting hurt. Lift-turning the client in hoyer lift battery was dead no one was their to show me charging battery. Call on-call they said someone should be on the way (Christen) no-one never showed up so I was totally untrained for that particular Home Zone Zone! Also their was other client their one was death and the other client like to take off running out the house I was the activities staff. So after hurting myself, and twisting my back and shoulder. I had to call the emergency squad 911 For help their was no one else their capable of helping me. ~~I had~~ 911 had to wait For the next staff to come in before (Emergency squad) trans porting me to hospital while I am in pain.

(2) After hurting and going threw pain and therapy with their therapist and Ohio health the doctor had [redacted] Put me on work restrictions doctor hebians at Ohio health already.

(cont. ON Back Side)

he took me off work restriction between Sept. 29 - Oct. 2, 2014 but I was still in Pain No hardly getting any Pain treatment therapy. the doctor had asked for several Pain tools to help my pain threw BWC they were denied Accept for the Steroids Shoot I Got in my shoulder, The Doctor Put me Back on Work Restriction Oct. 3 - 2014 Oct. 17-2014 After still in Pain. I dont what happen with the No-Call/-No Show Being Fired I called on-call manger that week and let them know that the doctor had put me back on restrictions. the Doctor's office Faxed Papers to their office that same day within the hour I had informed the by Phone and had came to the office. Call on-call Jessica to believed name. Was that Familiar with the office or anyone Fairly new. I was Fired terminated for No-Call No-Show and the had got the in formation The letter said call for any questions no-one never called me back. It said to ask Lindsey Bourgeois. I Left messages also.

IV. Previous lawsuits:

If you have been a Plaintiff in a lawsuit, for each lawsuit state the case number and caption. (Example, Case Number: 2:08-cv-728 and Caption: John Smith vs. Jane Doe).

Case Number	Caption
_____	_____ vs. _____
_____	_____ vs. _____
_____	_____ vs. _____

V. Relief

In this section please state (write) briefly exactly what you want the court to do for you. Make no legal argument, cite no case or statutes.

I state under penalty of perjury that the foregoing is true and correct. Executed on this 27 day of Sept., 2017.

Signature of Plaintiff

Columbus Center for Human Services, Inc.

October 8th 2014

To: Yolanda Mackey

From: *Lindsey Bourgeois*

RE: ***Termination***

*On October 4th 2014, you failed to arrive to work for scheduled shift without required notification. An employee is considered a" **No Call,No Show**" When no notification is provided or when notification is given one hour or more after their scheduled shift. As per policy, this results in termination of your employment with CCHS effective October 8th 2014.*

If any questions, please contact me at (614)-272-3248

Sincerely,

Lindsey Bourgeois

Lindsey Bourgeois

Department Manager

Columbus Center for Human Services Inc.

614-272-3248

Cc: Personnel file

Ohio | Bureau of Workers' Compensation

Physician's Report of Work Ability

Injured worker name	Claim number	Date of injury
Yolanda A. Mackey	14-319576	04/22/2014
Employer name and injured worker's position of employment at time of injury	**Date of last exam or treatment**	**Next appointment date**
Supported Community Living	10/03/2014	10/17/2014

Injured worker progress

1 The injured worker is progressing: ☐ As expected ☐ Better than expected ☐ Slower than expected
If a MEDCO-14 was previously completed for this injured worker, are there any changes to the information provided in Section 2 through 7 to report at this time? ☐ Yes ☐ No *If yes, proceed to section 2. If no, proceed to section 8.*

Work status

2 Did you review a description of the injured worker's job duties as they existed on the date of injury (former position of employment)? Check all applicable boxes.
☐ Yes, I was provided a job description (verbal or written) by the ☐ Injured worker ☐ Employer ☐ MCO
☐ No, I have not been provided a job description.
Select one of the three options below.
☐ Injured worker is temporarily not released to any work, including the former position of employment from (date): _____ to _____ . *Please complete required sections 4, 5, 6, 7 and 8.*
☑ Injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions, from (date): 10/03/2014 to 10/17/2014 . *Please complete required sections 3, 4, 5, 6, 7 and 8.*
The restrictions are: ☐ Permanent ☑ Temporary If temporary until what date? 10/17/2014
☐ Injured worker is released to the former position of employment without restrictions as of (date): _____
Is this date the day the injured worker actually returned to work? ☐ Yes ☐ No ☐ I don't know. *Proceed to section 8 and complete it.*

Injured worker's capabilities: Employer will use information in this section to evaluate available and appropriate work opportunities

3 How many total hours is this injured worker potentially able to work? reg _____ Hours in a day rg _____ Hours in a week

Upper extremities
The injured worker is able to perform simple grasping with: ☐ Left hand ☐ Right hand ☑ Both
The injured worker is able to perform repetitive wrist motion with: ☐ Left hand ☐ Right hand ☑ Both
The injured worker's dominant hand is: ☐ Left ☐ Right

Lower extremities
The injured worker is able to perform repetitive actions to operate foot controls or motor vehicles with: ☐ Left foot ☐ Right foot ☑ Both

Medications
The injured worker is able to safely perform work duties which, if applicable, may include operating heavy machinery or driving while taking prescribed medications: ☑ Yes ☐ No
If no, what are the potential side effects: ☐ Dizziness ☐ Drowsiness ☐ Impaired ability ☐ Other, please explain

Please indicate the following: N = Never, O = Occasionally, F = Frequently, C = Continuously

Lifting/carrying	N	O	F	C	Pushing/pulling	N	O	F	C	Activity	N	O	F	C	Activity	N	O	F	C
0 – 10 lbs.				✔	13 to 25 lbs.				✔	Bend				✔	Reach above shoulder	✔			
11 – 20 lbs.			✔		26 to 40 lbs.		✔			Squat				✔	Type/keyboard				✔
21 – 40 lbs.	✔				41 to 60 lbs.	✔				Kneel				✔	Driving				
41 – 60 lbs.	✔				61 to 100 lbs.	✔				Twist/turn				✔	Automatic				✔
61 – 100 lbs.	✔				100 + lbs.	✔				Climb	✔				Standard shift				

In an eight-hour workday, how many total hours is the injured worker potentially able to work?

Sit: ___ hours ☑ Continuously ☐ With break	Walk: ___ hours ☑ Continuously ☐ With break	Stand: ___ hours ☑ Continuously ☐ With break

Degree of functional impairment based on allowed psychological conditions only, if applicable.

	None	Mild	Moderate	Marked	Extreme
Activities of daily living: Self-care, personal hygiene, communication, ambulation, travel, sexual function, sleep, social and recreational activities and occupational functioning	☐	☐	☐	☐	☐
Social functioning: Capacity to interact and communicate effectively and get along with others	☐	☐	☐	☐	☐
Concentration, persistence and pace: Ability to sustain focused attention long enough to complete tasks commonly found in the workplace	☐	☐	☐	☐	☐
Adaptation: Ability to appropriately react to stressful circumstances, including the workplace; includes attendance, making decisions, scheduling or completing tasks and interacting with supervisors and co-workers	☐	☐	☐	☐	☐

Injured worker name	Claim number	Date of injury
Yolanda A. Mackey	14-319576	04/22/2014

Disability period information (all fields required, including site/location if applicable)

4 Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and ICD code for the conditions being treated due to the work-related injury. Please indicate if the condition is causing temporary total disability **(all fields required, including site/location, if applicable).**

Narrative description of the work-related condition	Site/Location If applicable	ICD code	Is the condition causing temporary total disability?
Sprain/Strain, Lumbar	Back, Lumbar	847.2	☐ Yes ☑ No
Sprain/Strain, Other specified sites of shoulder and upper arm	Shoulder/Upper Arm, Specified	840.8	☑ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

List all other conditions being treated (attach additional sheet if necessary).

Clinical findings

5 Provide your clinical and objective findings supporting your medical opinion outlined on this form. List any barriers to return to work and any reason for the injured worker's delay in recovery.

No patient positioning or lifting due to R shoulder pain.

Maximum medical improvement (MMI)

6 MMI is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability in spite of continuing medical or rehabilitative procedures. An injured worker may need supportive treatment to maintain this level of function. Note: periodic medical treatment may still be requested and provided.
Has the work-related injury(s) or occupational disease reached MMI based on the definition above? ☐ Yes ☑ No
If yes, give MMI date: _____ . If no, please provide the proposed treatment plan, including estimated duration of treatment (attach additional sheet if necessary).

Still in active treatment, see attached medical.

Vocational rehabilitation

7 Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions, and may provide job seeking skills or necessary retraining. Is the injured worker a candidate for vocational rehabilitation services focusing on return to work?
☐ Yes ☑ No If no, please explain why and provide your recommendations to help the injured worker return to employment.

Still in active treatment, see attached medical.

Treating physician signature - mandatory

I certify the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

8

Treating physician's name (please print legibly)			Physician PEACH number	
Paul T. Heban, MD			314394942	
Address	City	State	Nine-digit ZIP code	Telephone number
WorkHealth Southwest, 4079 Gantz Rd., Suite C	Grove City	OH	43123-4912	(614) 544-0030
Treating physician signature			Date	Fax number
Paul T Heban MD			01/16/2015	(614) 533-0060